Welcome To Our Office

Patient History

Today's Date ___________________________________

Last ___________________________________

First ________________ MI ______________

Street ___________________________________

City ___________________________________

State ________________ Zip Code __________

Home Phone ___________________________________

Work Phone ___________________________________

Cell Phone ___________________________________

Patient's SSN ___________________________________

Employer (or School) ________________________

Occupation (or Grade) ________________________

Spouse (or Parent's Name) ____________________

Marital Status Married___Single____Divorced____

Date of Birth ____________ Age ________________

Sex M F

Email Address ___________________________________

What is the major purpose of this visit? __________

____

Any problems with your current contact lenses or glasses?

____

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?

Name of friend or relative ____________________

If not referred, how did you choose our office? _______

☐Another Dr.

☐Insurance List

☐Saw Sign/Building

☐Newspaper/Radio/TV

☐Yellow Pages: Which directory? ______________

____

☐Web Page: Which Web Site? _______________

____

☐Other ___________________________________

The Office of Dr Gregory R. Barcus

Our Mission

Our eye care team provides high quality care, with a personal touch, for the best quality of life.

Insurance Information

Please note that insurance does NOT cover the Contact Lens Follow-Up Evaluation.

Vision Insurance ___________________________________

Subscriber Name ___________________________________

Subscriber SSN ___________________________________

Subscriber Birth Date ______________________________

Primary Medical Insurance___________________________

Subscriber Name ___________________________________

Subscriber SSN ___________________________________

Subscriber Birth Date ______________________________

Do you participate in a flex spending account?

☐Yes ☐No

How will you settle your account today?

☐Cash ☐Check ☐Credit Card

Lifestyle Questions

Do you (check box if your answer is yes)

- ☐ work at a computer? If yes, please complete computer questionnaire.
- ☐ think you might benefit from thinner, lighter lenses?
- ☐ have interest in a "test drive" of the latest contact lens designs
- ☐ spend time outdoors? How much? _____ Hrs/week
- ☐ have prescription sunwear?
- ☐ prefer not to wear your glasses at times?
- ☐ want information on Laser Vision Correction surgery
- ☐ have more than 1 pair of current Rx eyewear?
- ☐ have children?
- ☐ have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

☐Blurry Vision ☐Burning

☐Cataracts ☐Corneal Abrasions

☐Crossed eye/Eye turn ☐Double Vision

☐Eye Infections ☐Eye Injury

☐Flash of light ☐Floaters/Spots

☐Glaucoma ☐Grittiness

☐Headaches ☐Iritis/Uveitis

☐Itchiness ☐Lazy Eye

☐Macular Degeneration ☐Occasional dryness

☐Retinal Detachment ☐Sunlight Sensitivity

☐Tearing ☐Trouble seeing at night

☐Uncomfortable glasses

☐Other eye disorder(s) _________________________

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician ___________________________

Town ___________________________

Date of Last Physical Check-up ___________________________

CURRENT MEDICATIONS (Rx or Over the Counter)

(List name of medications including eye drops, vitamins, & birth control pills) ___________________________

____

Allergies to medications? ☐Yes ☐No

If so, what medications? ___________________________

____

Have you had any surgeries? ☐Yes ☐No

Do you use cigarettes/tobacco, alcohol, or other substances? ☐Yes ☐No

Have you ever been diagnosed or treated for the following health problems?	**Yes**	**No**
Allergies	☐	☐
Arthritis	☐	☐
Blood/Lymph	☐	☐
Bronchitis	☐	☐
Cancer	☐	☐
Cholesterol	☐	☐
Diabetes	☐	☐
Digestive	☐	☐
Ears/Nose/Throat	☐	☐
Endocrine	☐	☐
Eczema/Rashes	☐	☐
Fatigue	☐	☐
Fevers	☐	☐
Genitourinary	☐	☐
High Blood Pressure	☐	☐
Integumentary(Skin)	☐	☐
Kidney	☐	☐
Muscle/Bone	☐	☐
Neurological	☐	☐
Psychological	☐	☐
Respiratory	☐	☐
Sinus	☐	☐
Throat Infections	☐	☐
Thyroid	☐	☐
Unusual weight losses/gains	☐	☐

Dr. Gregory R. Barcus

We are HIPPA compliant!

Patient Eye History

Date of Last Eye Exam ___________________________

By Whom? ___________________________

Have you ever tried contact lenses? ☐Yes ☐No

Do you currently wear contact lenses? ☐Yes ☐No

What kind? ___________________________

Solutions used ___________________________

Are you satisfied with the vision and comfort of your contact lenses? ☐Yes ☐No

Would you prefer clear contact lenses or colored contact lenses? ☐Clear ☐Colored

If you wear bifocals, do the lines or head tilting bother you? ☐Yes ☐No

Family Medical/Eye History

(Check all that apply)

Is there a family medical history of any of the following: (Please check boxes) Relationship (Mother's or Father's side)

Blindness ☐Yes ☐No___________________________

Cataracts ☐Yes ☐No___________________________

Corneal Problems ☐Yes ☐No___________________________

Diabetes ☐Yes ☐No ___________________________

Glaucoma ☐Yes ☐No ___________________________

Heart Disease ☐Yes ☐No ___________________________

Lazy Eye ☐Yes ☐No ___________________________

Macular Degeneration ☐Yes ☐No___________________________

Retinal Problems ☐Yes ☐No ___________________________

Please be advised:

If you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Dr. Barcus's office.

If your insurance company has not reimbursed our office in full within 60 (or 90) days, your credit card will be utilized and your insurance company will then pay you directly. (If by mistake your insurance company sends the payment check to us, we will of course sign over and forward the check directly to you.)

Please enter your credit card number and expiration date.

CC#:___________________________

Expiration Date: ___________________________

Signature ___________________________